REDWOOD PEDIATRICS
An Affiliate of Children's Mercy

Patient Name _____ M F Date of Birth: _____

Parent Names _____ Sisters _____ Brothers _____

Active or Chronic Problems Check all that apply

☐ ADHD	☐ Deafness	☐ Diabetes	☐ Heart Disease	☐ Urinary Reflux
☐ Allergies	☐ Depression	☐ Frequent Ear Infections	☐ Mental illness	☐ Frequent or Recurrent UTI
☐ Anxiety	☐ Developmental Delay	☐ Eczema	☐ Migraines	☐ Seizures
☐ Asthma	☐ DDH – hip dysplasia	☐ Elevated Cholesterol	☐ Obesity	☐ Sickle Cell
☐ Cancer (type):		☐ Headaches	☐ Scoliosis	☐ Other (write below)

Please list other active or chronic problems _____

Other doctors and/or specialists your child sees _____

Patient's Drug/Food Allergies & Reaction _____

Current Medications Please list all over the counter medications, supplements, herbal medications your child takes

Medication	Dosage	Times per Day	Prescribed by

Family History

☐ Adopted

Please check any of the following conditions that are present in 1st degree relatives (siblings, parents):

_____Heart Problems under the age of 20 _____Thyroid Problems _____Asthma

_____Cholesterol Problems _____Eczema _____Nasal Allergies

Social History

Father's Occupation: _____ ☐ Full Time ☐ Part time ☐ Student

Mother's Occupation: _____ ☐ Full Time ☐ Part time ☐ Student

Parent's Relationship: ☐ Married ☐ Living Together ☐ Single Parent ☐ Guardian ☐ Foster Parent ☐ Same Sex Parents ☐ Separated ☐ Divorced

Smokers in the Home: Y N Pets in the house (type): _____

Surgical History

Has your child had any of the following operations? If yes, fill in the year of surgery

	Year	Admitted (Y/N)	Reason
Ear Tubes Placed			
Tonsils/Adenoids Removed			

Other operations/procedures: _____

Hospital admissions: _____